

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

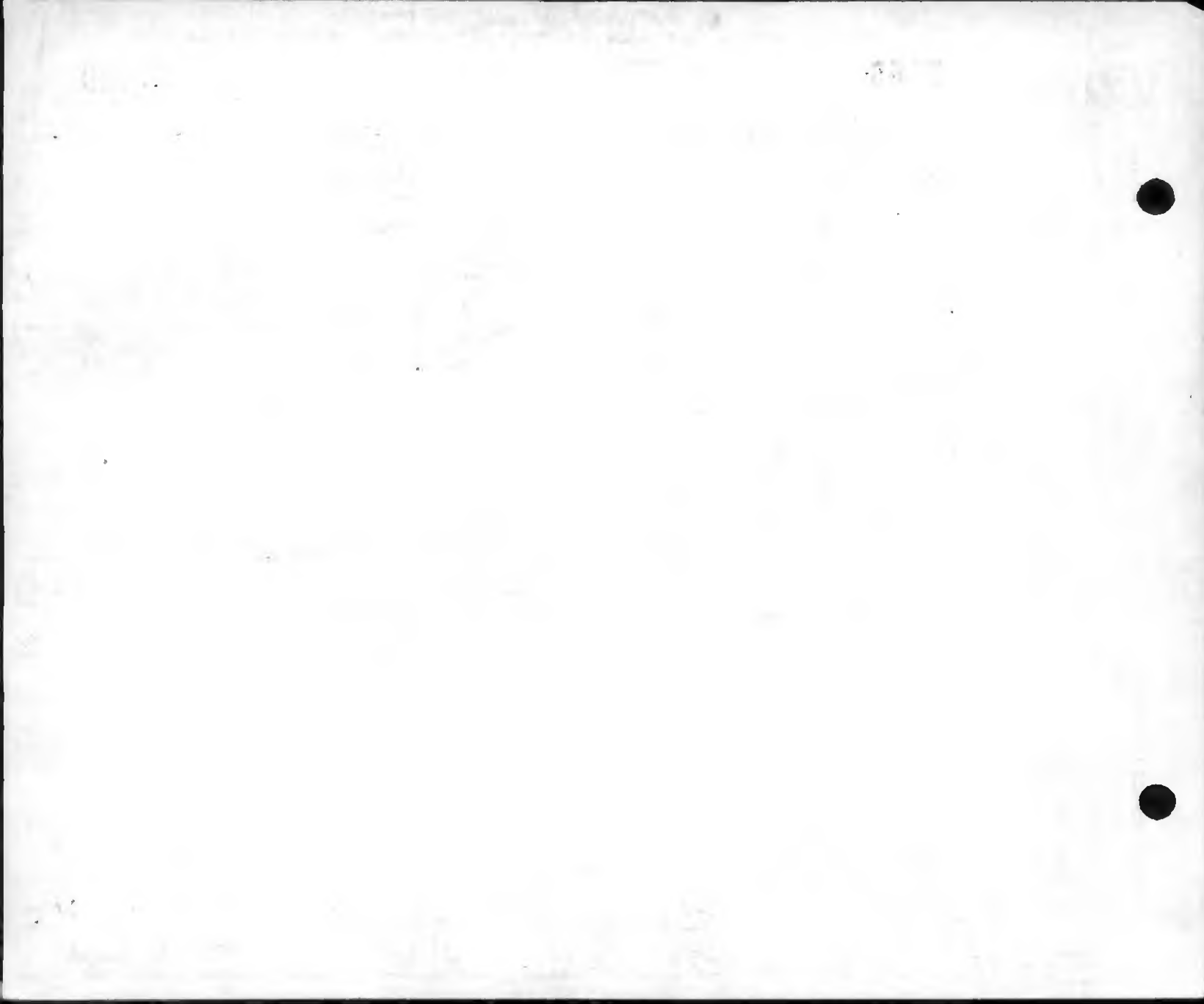
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07463

07439

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1</u>		d. STREET ADDRESS <u>Route 1</u>	
3. NAME OF DECEASED (Type or print) <u>Addie Mildred Andersen</u>		4. DATE OF DEATH <u>May 12</u> 19 <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 23, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>R. Lee Waller</u>		14. MOTHER'S MAIDEN NAME <u>Edith Rosa</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-3780</u>	
17. INFORMANT <u>MRS ROSA M. Taylor</u>		Address <u>Ocean City Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY occlusion, Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD with myocardial &amp; cerebral</u> (c) <u>INSUFFICIENCY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u> <u>154 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		22. DATE SIGNED <u>May 15, 67</u>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bealton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/15/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u>		23d. LOCATION (City or Town) (County) (State) <u>Bealton Wm Md</u>	
24. FUNERAL DIRECTOR <u>ANNA A. Burbage</u>		25a. REC'D BY REGISTRAR <u>MAY 19 1967</u>	
ADDRESS <u>Bealton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07464

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07440

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>303 Willow St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Prince</u> Middle <u>Albert</u> Last <u>Ashby</u>		4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1912</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>	9. AGE (In years, lost birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Ashby</u>		14. MOTHER'S MAIDEN NAME <u>Odella Hardy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8799</u>	
17. INFORMANT <u>Odella L. Ashby</u>		Address <u>303 Willow St. Snow Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Hypertensive Heart</u> DUE TO (c) <u>Disease</u> Interval between onset and death <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>David R. Ruff</u> M.D. EXAMINER'S NAME (Type) <u>DAVID RUFF</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cool Spring Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Griddletree Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Sarg</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u> JUN 2 1967	
26. REGISTRAR'S SIGNATURE		27. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07465		07441									
1. PLACE OF DEATH a. COUNTY <b>Worcester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Stockton</b> c. LENGTH OF STAY IN ID <b>3 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holland Nursing Home</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City 23-1</b> d. STREET ADDRESS <b>R.F.D. 3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LINCIE</b>			First <b>ELLA</b>			Middle <b>BARNES</b>			Last		
4. DATE OF DEATH <b>May 20 1967</b>		Month <b>May</b>		Day <b>20</b>		Year <b>1967</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1877</b>		9. AGE (in years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Accomack County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hinman</b>						14. MOTHER'S MAIDEN NAME <b>Mary Wessells</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-48-1281</b>		17. INFORMANT <b>Mrs Robert Northam, Pocomoke, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIO-SCLEROSIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ANKLY LOSED JOINTS - LOWER EXTREMITIES</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <b>May 14, 1967</b> Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>May 14, 1967</b> to <b>May 20, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1967</b> , and that death occurred at <b>6:15</b> M, from the causes and on the date stated above. 22a. SIGNATURE <b>Robert C. Lamar</b> 22b. DATE SIGNED <b>5/21/67</b> 22c. PHYSICIAN'S NAME (Type) <b>ROBERT C. LAMAR</b> 22d. ADDRESS <b>Snow Hill, Md</b> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>5-22-1967</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Rural-Pocomoke, Maryland</b> 24. FUNERAL DIRECTOR <b>Robert H. Watson</b> ADDRESS <b>Pocomoke City, Md.</b> 25a. REC'D BY REGISTRAR <b>MAY 20 1967</b> 25b. REGISTRAR'S SIGNATURE <b>James Judge</b>											

ASTROSCOPIC  
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ARMED JINTS - LACK EXTRACTS

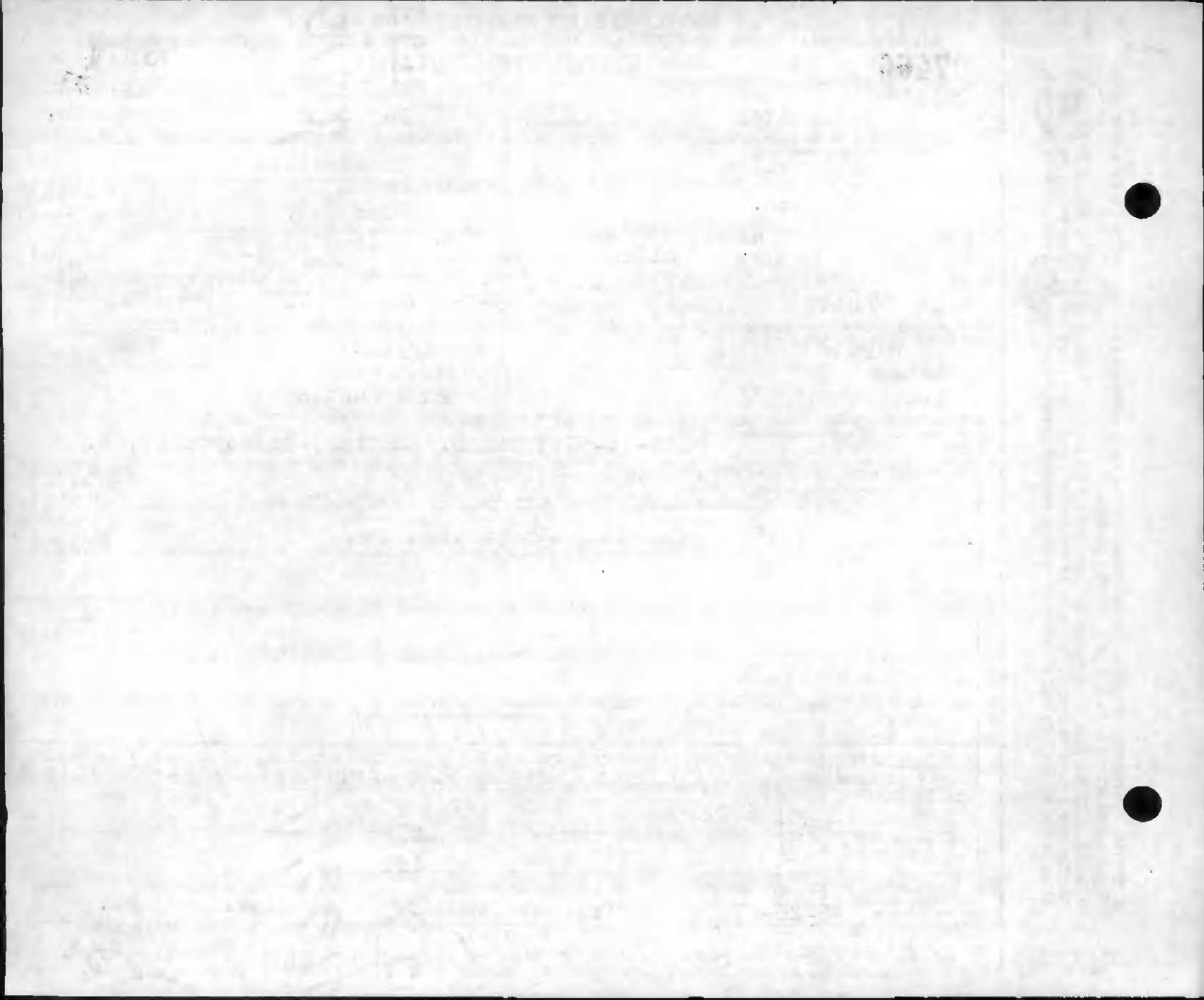
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
07466					CERTIFICATE OF DEATH					08874									
1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home Res.</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b> d. STREET ADDRESS <b>Home Res.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <b>Elva</b> Middle <b>Allen</b> Last <b>Bunting</b>					4. DATE OF DEATH Month <b>5-</b> Day <b>23</b> Year <b>1967</b>														
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-1-1896</b>		9. AGE (in years last birthday) <b>70</b> yrs.		10. FINDER 1 YEAR Months <b>7</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. FINDER 24 HRS. Months <b>7</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Levi Bunting</b>					14. MOTHER'S MAIDEN NAME <b>Anna Bunting</b>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW I</b>					16. SOCIAL SECURITY NO. <b>214-34-5351</b>					17. INFORMANT <b>Eva L. Bunting, Bishopville, Md.</b> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>H201</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>4/26/67</b> , 19 <b>67</b> , to <b>5/15/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/15/67</b> , 19 <b>67</b> , and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.																			
22a. SIGNATURE <b>[Signature]</b>										22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>										22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>5-26-67</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Oddfellow's Cemetery</b>					23d. LOCATION (City, town or county) (State) <b>Bishopville Md.</b>				
24. FUNERAL DIRECTOR <b>A. Douglas Nelson, Frankford, Md.</b> ADDRESS										25a. REC'D BY REGISTRAR <b>[Signature]</b> DATE <b>JUN 27 1967</b>					25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				





14  
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

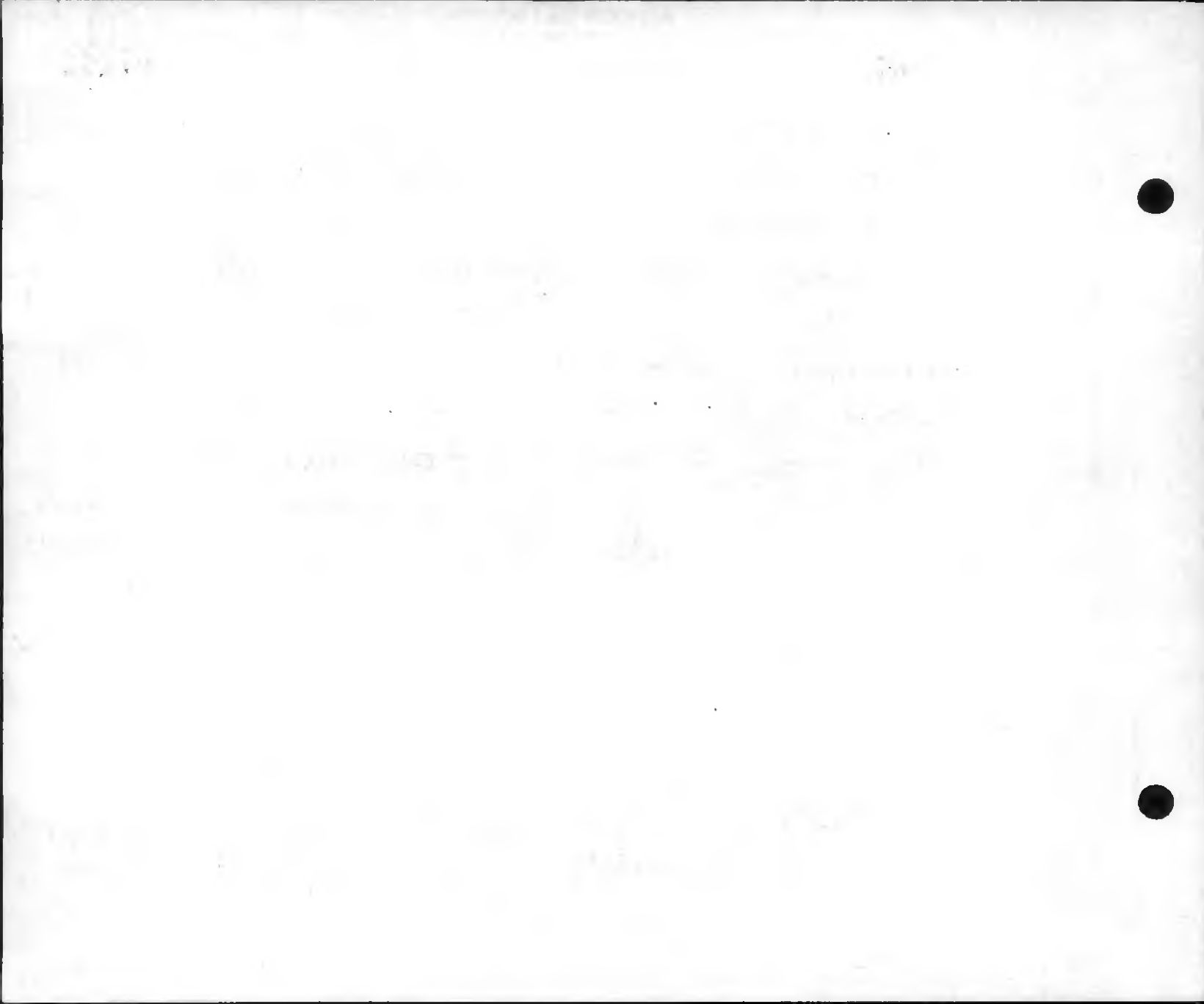
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07467

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07442

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>NORTHAMPTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY in 1b <u>1 day</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Charles</u>		d. STREET ADDRESS <u>RFD 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1105 N. Baltimore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>EDNA</u> Last <u>CHAPMAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 9, 1899</u>
9. AGE (In years last birthday) <u>67</u>		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Coard S. Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Addie Mears</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-32-9933</u>	
17. INFORMANT <u>Miss Hilda Harrison</u>		Address <u>R1 Cape Charles, VA</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>F. J. Townsend</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. J. TOWNSEND</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Ocean City, Md - Worcester Co.</u>		DATE SIGNED <u>MAY 27 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cape Charles Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cape Charles Va.</u>
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin and</u>		25a. REC'D BY REGISTRAR <u>31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07468

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

07443

1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Worcester</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Stockton</u>		c LENGTH OF STAY N 15 c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Stockton</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS <u>P.O. Box 153</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Douglas</u>		4 DATE OF DEATH Month Day Year <u>May 15 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 3, 1883</u>
9 AGE (in years, months, and days) <u>83</u>		10a USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Laborer</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11 BIRTHPLACE (State or foreign country) <u>Md.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>James Douglas</u>	
14 MOTHER'S MAIDEN NAME <u>Sarah ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>220-52-7964</u>		17. INFORMANT Address <u>Elsie Douglas Stockton, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - poorly controlled</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>David R. FAT</u>		22. DATE SIGNED <u>5/17/67</u>	
EXAMINER'S NAME (Type) <u>DAVID R. FAT</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>5-20-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Home Beneficial Ceme</u>	23d LOCATION (City or town) (County) (State) <u>Stockton Worcester Md.</u>
24 FUNERAL DIRECTOR <u>Samuel Long</u>		25a REC'D BY REGISTRAR DATE <u>MAY 18 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Richard Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

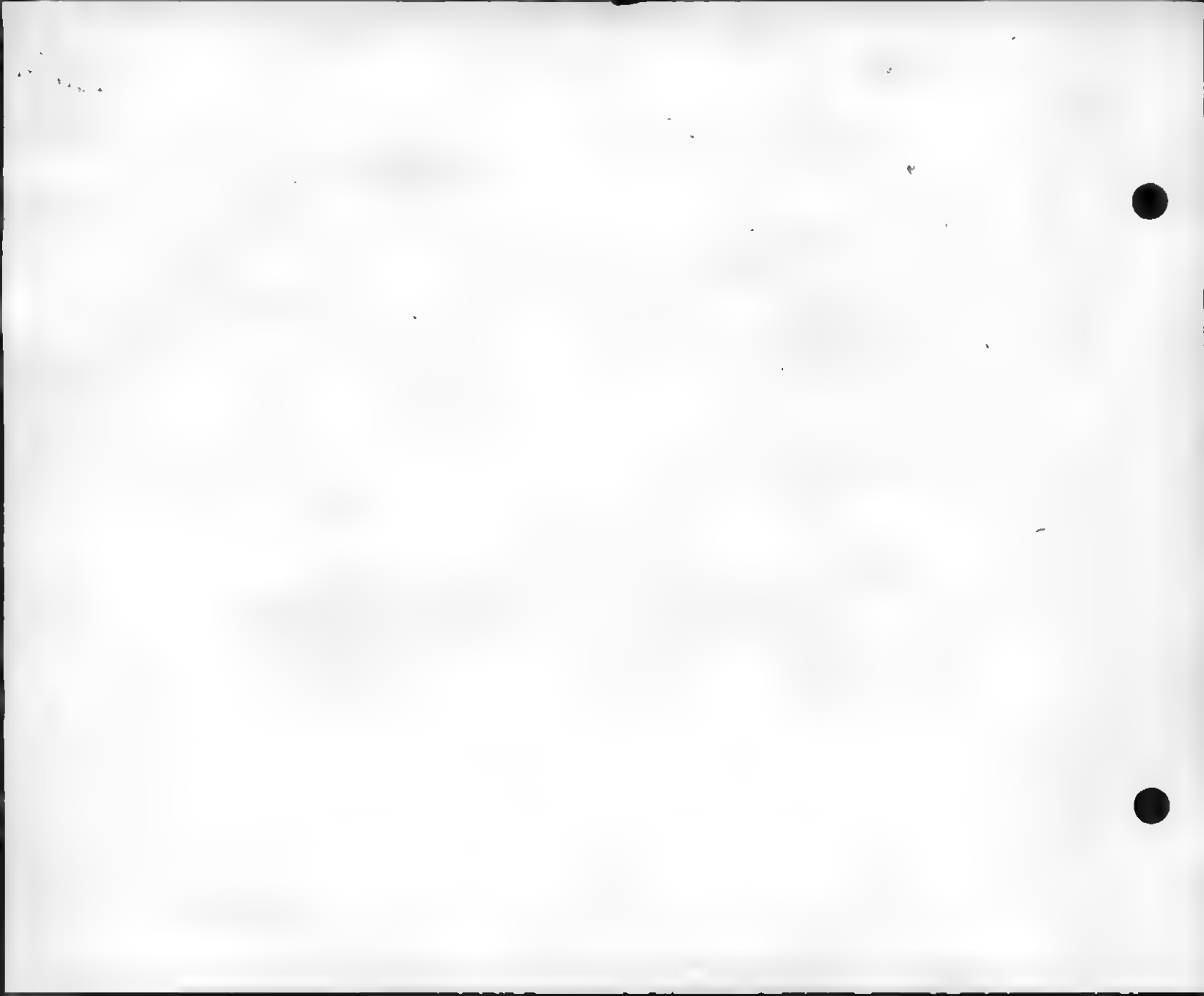
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07469

CERTIFICATE OF DEATH

07444

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>Stockton</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Stockton Md.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holland Nursing Home</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Rew</u> Last <u>Shadding</u>				4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1889</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Blount</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Rew</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Somers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>230-01-3223</u>		17. INFORMANT <u>Adrian Shadding H. Peterson</u> Address <u>1/1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>60</u> to <u>May</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>5-20</u> , 19 <u>67</u> , and that death occurred at <u>5</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>David Rafat</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>5/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>				22d. ADDRESS <u>SNOW HILL Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkside</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkside Va</u>	
24. FUNERAL DIRECTOR <u>J. Richard Johnson</u>				25a. REC'D BY REGISTRAR <u>Parkside, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MAYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY <u>Worcester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MD</u> COUNTY <u>PRINCE GEORGES</u>							
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c LENGTH OF STAY IN 1b <u>1 DAY</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sunset View Motel 48th St</u>		d STREET ADDRESS <u>7703 Alpine St.</u>				e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Timothy</u> First Middle Last		4. DATE OF <u>MAY 27</u> Month Day Year		19 <u>67</u>					
5. SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 28 1948</u>		9. AGE (In years last birthday) <u>19</u> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>				12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>BURRIS HOLDEN</u>		14 MOTHER'S MAIDEN NAME <u>FLORENCE RAYFORD</u>							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>578-64-7112</u>		17 INFORMANT <u>Ocean City, Md Police Dept.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> INSTANT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ethylism, acute</u>									
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Ethylism, Acute. Blood alcohol 0.42 percent vomited while asleep or unconscious and choked</u>							
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Motel</u>		20f (City or town) <u>Worc</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>MAY 27, 67</u>	
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>		Address <u>Ocean City, Md</u>		City or town, county, state <u>Worcester Co.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>5-31-1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d LOCATION (City or town) <u>Suitland</u>		(County) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd Suitland Maryland</u>				25a REC'D BY REG STRAR <u>MAY 31 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
37471						CERTIFICATE OF DEATH			07446				
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> c. LENGTH OF STAY IN 1b <u>75 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>JEFFERSON ST</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>JEFFERSON ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>SEVERN</u> Middle <u>J.</u> Last <u>HUDSON</u>						4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1967</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 10, 1880</u> 86 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>8</u> Days <u>6</u> Hours <u>1</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM A. HUDSON</u>						14. MOTHER'S MAIDEN NAME <u>ROSINA McCABE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MR. WILLIAM S HUDSON</u>		Address <u>BERLIN MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 1962, to <u>May 11</u> , 1967, that (I) (we) last saw the deceased alive on <u>May 11</u> , 1967, and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Frank E. Gantz, Jr.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/13/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Gantz, Jr. M. D.</u>						22d. ADDRESS <u>5 Bay St. Berlin, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>							
24. FUNERAL DIRECTOR <u>Anna A. Buehage</u>		ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



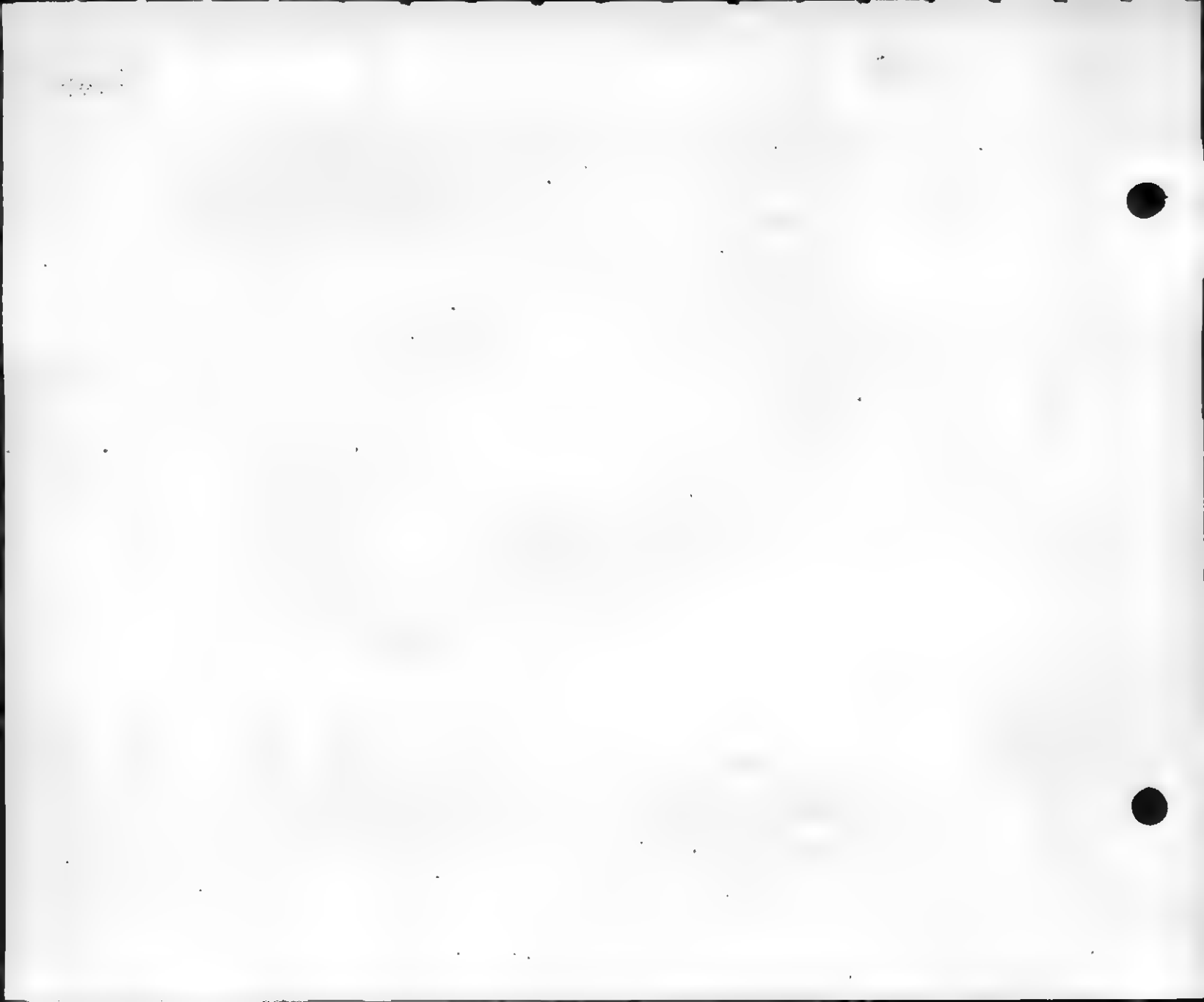
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
07472					07447					
1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>			c. LENGTH OF STAY IN 1b <b>10 months</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Berlin Nursing Home</b>					d. STREET ADDRESS <b>405 Laurel Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>REBECCA</b> Middle <b>LEE</b> Last <b>JOYNES</b>					4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 28, 1881</b>		9. AGE (In years last birthday) <b>85</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Northampton County, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George W. West</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Richardson</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs Willis E. Boole, Pocomoke City, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chs. Myocarditis</b> <b>4/4/3X</b> DUE TO (b) <b>Neurachyran</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Hypertension</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>May 2 - , 1967</b> , to <b>May 13 - , 1967</b> , that (I) (we) last saw the deceased alive on <b>May 2 - 1967</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.										
22a. SIGNATURE <b>Chas R Law</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-13-67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles R. Law</b>					22d. ADDRESS <b>Berlin Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-16-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Redbank Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Marionville, Virginia</b>			
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>					ADDRESS <b>Pocomoke City, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07473

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07448

1 PLACE OF DEATH a. COUNTY <i>Worcester</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree</i>		c. LENGTH OF STAY N 1b		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Worcester</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Girdletree</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) <i>Helen E. Niblett</i>		4 DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1967</i>		5 SEX <i>Female</i>		6 COLOR OR RACE <i>White</i>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <i>May 21, 1895</i>		9 AGE (In years lost birthday) <i>71</i> yrs		10 IF UNDER 1 YEAR Months <i>6</i> Days <i>10</i> Hours <i>4</i> Min <i>0</i>		11 IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas McCord</i>		14. MOTHER'S M.A.DEN NAME <i>Ida Funk</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ernest C. Niblett</i> Address <i>Girdletree, Maryland</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO <i>Thrombophlebitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Asperosclerotic Heart Disease</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs 10k.</i>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Asperosclerotic Heart Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <i>David Rafat</i> EXAMINER'S NAME (Type) <i>DAVID RAFA</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city, town, or county)		22. DATE SIGNED <i>5-3-67</i>		23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5-6-1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Howard County, Maryland</i>		24. FUNERAL DIRECTOR <i>Lilly &amp; Zeiler Inc. 1901-07 Eastern Ave.</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 4 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

2. 3

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1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. I, FUNERAL DIRECTOR, Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

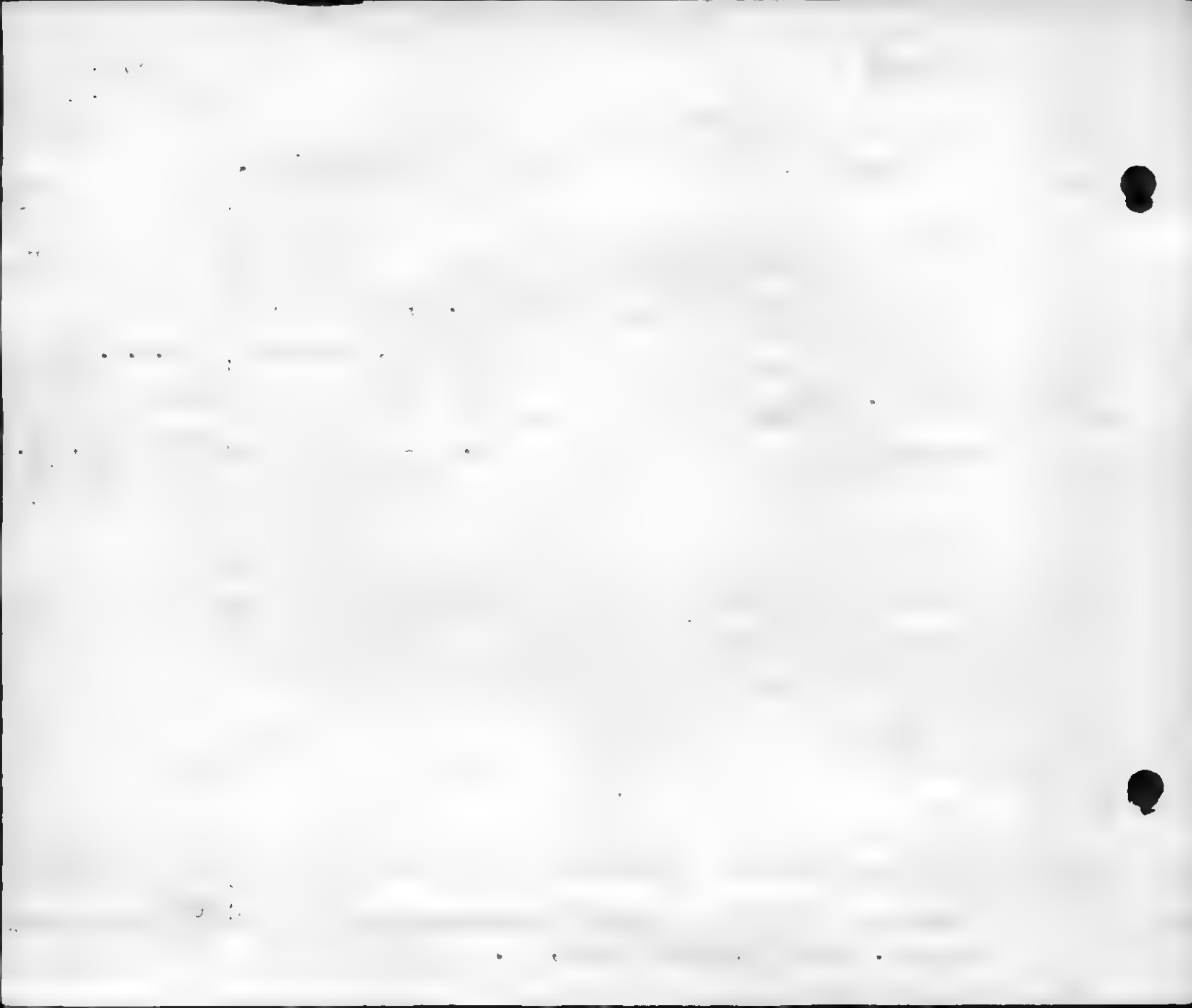
VR AISME  
5M 1/63

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07475

07450

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>POCOMOKE CITY.</b>		c. LENGTH OF STAY IN 1b <b>8 WEEKS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b>		f. COUNTY <b>WORCESTER</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>POCOMOKE CITY 212 MARKET ST.</b>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>ORVILLE EDWARD PACE</b>						4. DATE OF DEATH Month Day Year <b>MAY 21 19 67</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 1, 1931</b>		9. AGE (In years last birthday) <b>35 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TECHNICIAN</b>						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) <b>CRAWFORD, NEBRASKA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>													
13. FATHER'S NAME <b>DAMES O. PACE</b>						14. MOTHER'S MAIDEN NAME <b>ROSELLA GALLIGAN</b>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address <b>MRS. ORVILLE PACE PRINCESS ANNE, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>'733</b> DUE TO <b>Carbon Monoxide Asphyxia</b> Conditions, if any, which gave rise to immediate cause (b) <b>3 hrs.</b> (c) <b>Interval BETWEEN ONSET AND DEATH</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Reactive Depression</b>																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>DAVID RAFAI</b> <b>5/21/67</b>																													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>						22b. DATE THEREOF <b>5/25/1967</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MOUNTVIEW CEMETERY</b>				22d. LOCATION (City, town, or county) <b>BILLINGS, MONTANA</b>																	
23. FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>						23b. ADDRESS <b>PRINCESS ANNE, MD.</b>						24a. REC'D BY REGISTRAR <b>MAY 31 1967</b>						24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

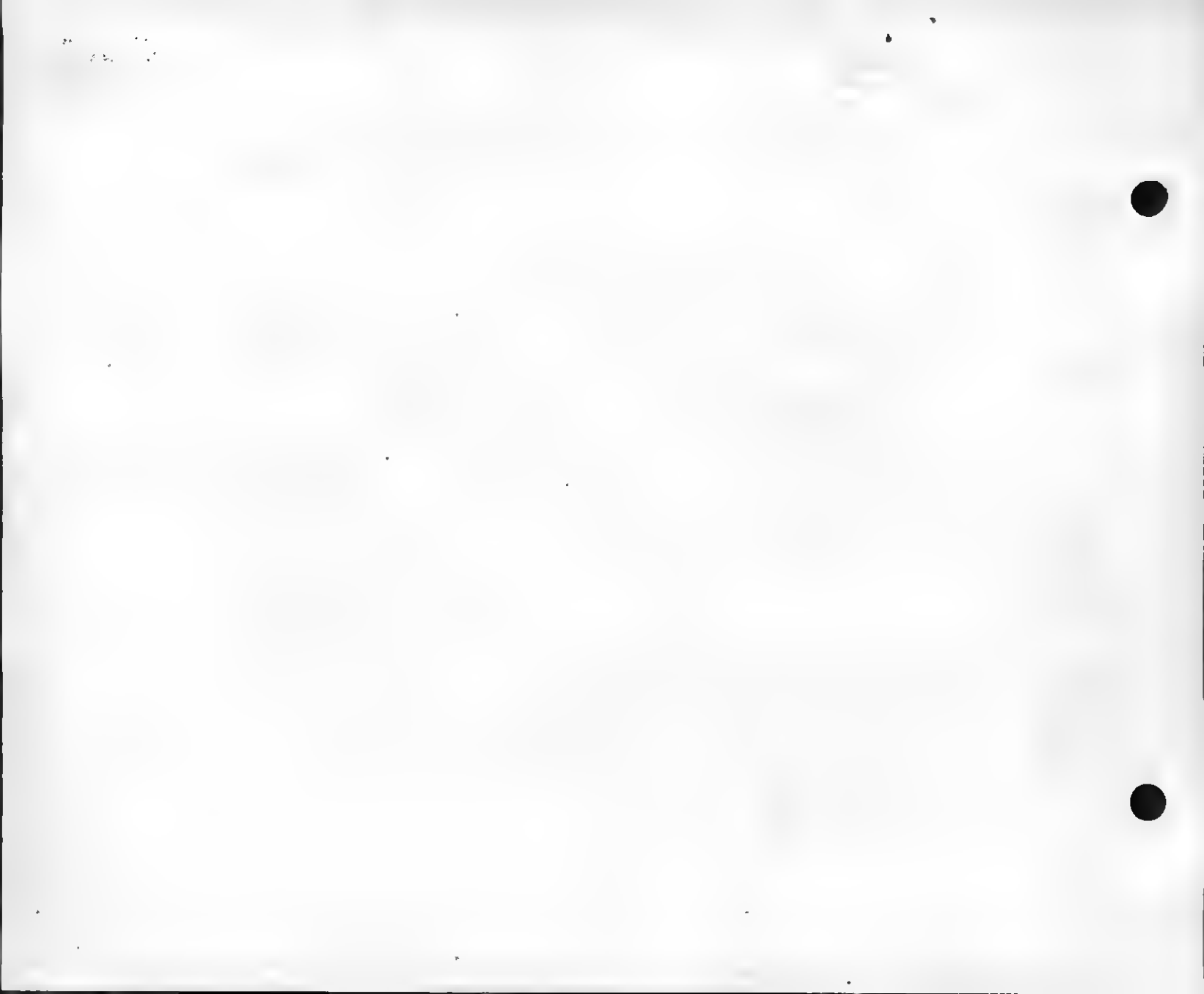
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07474

07449

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Stockton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bay Road				d. STREET ADDRESS Bay Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM OSCAR PARSONS				4. DATE OF DEATH Month Day Year May 22 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 13, 1882		9. AGE (In years last birthday) yrs 85	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore Henry Parsons				14. MOTHER'S MAIDEN NAME Henrietta Tarr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO 220-32-1176		17. INFORMANT Mrs Mary A. Parsons, Stockton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 532X Cerebral Thrombosis DUE TO (b) Cerebral atherosclerosis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 19 64 to May 19 67, that (I) (we) last saw the deceased alive on 5-2-1967, and that death occurred at M, from causes and on the date stated above							
22a. SIGNATURE David R. F. W. M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DAVID RA FAT		22d. ADDRESS Snow Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-25-1967	23c. NAME OF CEMETERY OR CREMATOR Porterville Methodist		23d. LOCATION (City or Town) (County) (State) Stockton, Wor., Md.			
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR DATE MAY 29 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07476

CERTIFICATE OF DEATH

07451

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>207 S. Washington St.</b>		d. STREET ADDRESS <b>207 S. Washington St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE E. SHOCKLEY</b>		4. DATE OF DEATH Month Day Year <b>May 1, 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 6, 1902</b>
9. AGE (in years last birthday) <b>64 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads Comm.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Shockley</b>		14. MOTHER'S MAIDEN NAME <b>Dollie Hancock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-42-2443</b>	
17. INFORMANT <b>Mrs. Myrtle D. Shockley</b>		Address <b>Snow Hill Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cerebral thrombosis</b> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4122</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 1, 1967</b> to <b>May 1, 1967</b> that (I) (we) last saw the deceased alive on <b>May 1, 1967</b> , and that death occurred at <b>12:15 M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>John T. Bulkeley</b>		22b. DATE SIGNED <b>5-5-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John T. Bulkeley MD</b>		22d. ADDRESS <b>Pine Bluff Rd. Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/3/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Whetcoat Methodist</b>	23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Maryland</b>
24. FUNERAL DIRECTOR <b>Seald C. Lounsbury</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be mailed as a burial permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07452

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Pocomoke</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Carbie E. Smack</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/4/93</b>	9. AGE (In years last birthday) <b>73</b> y/s	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>		11. BIRTHPLACE (State or foreign country) <b>Worcester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Smack</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>216561276</b>		17. INFORMANT <b>Dorothy Bennett, Salisbury, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic Heart Disease</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost) (b) <b>Dis ease</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alcoholism</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>David Rafat</b> EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			22. DATE SIGNED <b>5-16-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 18/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Meth.</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke, Maryland</b>	
24. FUNERAL DIRECTOR <b>Norman A. ...</b> ADDRESS <b>Snow Hill, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

10/1/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Stockton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Stockton</u> d. STREET ADDRESS <u>Route 2, Box 109</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frank</u> Middle <u>David</u> Last <u>Taylor</u>						<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>9</u> Year <u>1967</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 18, 1891</u>		<b>9. AGE</b> (In years) <u>75</u> yrs. <u>75</u> Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Dallas Taylor</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Hester ?</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <u>218-20-5552A</u>		<b>17. INFORMANT</b> Address <u>Route 2</u> <u>Gladys Taylor Stockton, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> (b) <u>Cerebral Vascular Accident</u> (c) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>6 weeks</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>5/65</u>, 19<u>65</u>, to <u>5/9</u>, 19<u>67</u>, that (I) last saw the deceased alive on <u>5/9/67</u>, 19<u>67</u>, and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>D. F. Fletcher, Jr.</u>						<b>22b. DATE SIGNED</b> <u>5/10/67</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. F. Fletcher, Jr.</u>			
<b>22d. ADDRESS</b> <u>Horsey, Va.</u>						<b>22e. ADDRESS</b> <u>Accomack Co.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5-13-67</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Coolspring Cem.</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>Ward, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Samuel Lange</u>						<b>25a. REC'D BY REGISTRAR</b> <u>Charles J. J.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J. J.</u>			
<b>25c. ADDRESS</b> <u>New Church, Va.</u>						<b>25d. DATE</b> <u>MAY 15 1967</u>					

1977

Mr. & Mrs. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07473		Item 2		0300 5/11/67		07454			
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> c. LENGTH OF STAY IN 1b <u>13</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BERLIN NURSING HOME</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> <u>Snow Hill</u> d. STREET ADDRESS <u>MAIN ST</u> <u>Bay St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>HETTIE</u> Middle <u>A.</u> Last <u>WEST</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>2</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 8, 1880</u>		9. AGE (in years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>COULBOURG DIST. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BURTON WEST</u>					14. MOTHER'S MAIDEN NAME <u>HETTIE A. RUARK</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. MILDRED DAVIS</u> Address <u>BERLIN, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u> <u>4922</u> DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Arthritis</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-67</u> to <u>5-2-67</u> , that (I) (we) last saw the deceased alive on <u>3-30-67</u> and that death occurred <u>6:4</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Clifford E. Schott</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott</u>					22d. ADDRESS <u>Berlin Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CHURCH YARD</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill Wor. MD</u>			
24. FUNERAL DIRECTOR <u>Anna R. Burbage</u> <u>Berlin Md.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>MAY 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text appears to be a list or series of entries, possibly related to a collection or inventory.]*